Nos. 23-726 & 23-727

IN THE

Supreme Court of the United States

MIKE MOYLE, SPEAKER OF THE IDAHO HOUSE OF REPRESENTATIVES, ET AL., *Petitioners*,

v.

UNITED STATES, *Respondent*.

STATE OF IDAHO, *Petitioner*,

v.

UNITED STATES, *Respondent*.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF AMICUS CURIAE PUBLIC CITIZEN IN SUPPORT OF RESPONDENT

NANDAN M. JOSHI
Counsel of Record
ALLISON M. ZIEVE
SCOTT L. NELSON
PUBLIC CITIZEN
LITIGATION GROUP
1600 20th Street NW
Washington, DC 20009
(202) 588-1000
njoshi@citizen.org

Attorneys for Amicus Curiae

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INTEREST OF AMICUS CURIAE*

Public Citizen, a consumer advocacy organization with members in all 50 states, appears before Congress, administrative agencies, and the courts on a wide range of issues. Public Citizen is a longstanding advocate of policies to improve access to health care, and it supports federal initiatives to expand such access by lowering the cost of health care and removing other barriers that prevent individuals from obtaining needed care.

Many federal health care programs, including Medicare and Medicaid, use federal funding to support the provision of medical services to beneficiaries. These programs typically impose various substantive obligations on program participants. Of relevance here, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals that participate in Medicare to screen emergency room patients and provide treatment to stabilize emergency medical conditions, and generally prohibits hospitals from transferring patients before they are stabilized. Hospitals that do not comply with those requirements face termination from the Medicare program, 42 U.S.C. § 1395cc(b)(2), as well as liability for civil penalties and damages, *id.* § 1395dd(d).

Public Citizen submits this brief because it is concerned that petitioners' arguments, if accepted, would weaken EMTALA's protections and undermine a range of other conditions on federal subsidies, thereby impeding access to health care throughout the nation.

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* This brief was not authored in whole or part by counsel for a party. No one other than amicus curiae made a monetary contribution to preparation or submission of the brief.

SUMMARY OF ARGUMENT

I.A. EMTALA provides that Medicare-funded hospitals "must provide … such treatment as may be required to stabilize" a medical condition. 42 U.S.C. § 1395dd(b)(1)(A). That language unambiguously imposes a mandatory duty on hospitals—a duty that is backed up by enforcement provisions that impose civil penalties and damages liability on hospitals and doctors that fail to comply with their EMTALA obligations. EMTALA also recognizes that state law may conflict with the statute's federal requirements and expressly preempts conflicting state laws. A state law that bars a Medicare-funded hospital from providing a particular treatment needed to stabilize a patient, where the hospital can otherwise provide that treatment, conflicts with EMTALA and is therefore preempted.

B. EMTALA defines a hospital's duty to stabilize a medical condition in terms of providing "treatment" necessary to prevent deterioration of a condition that poses a serious health risk to a patient. The ordinary meaning of "treatment" encompasses the range of actions or procedures used to treat a medical condition. As the record indicates and as this Court has long recognized, the appropriate "treatment" for preventing deterioration of certain medical conditions will be to terminate a pregnancy. Other federal laws that associate abortion with the treatment of medical conditions reinforce this conclusion.

Under EMTALA, then, a hospital has a duty to provide treatments that it is capable of providing, including abortion, when those treatments are required to stabilize a patient's emergency medical condition—that is, to prevent a deterioration of the

medical condition that would create a serious health risk for the individual. Under Idaho law, however, a hospital may not lawfully provide abortions in situations where EMTALA would require it to do so. In those situations, EMTALA and Idaho law conflict, and the federal law preempts the state law.

Petitioners' argument that states may decide what constitutes a "treatment" under EMTALA overlooks the statute's plain text and lacks merit. EMTALA does not delegate the authority to interpret the meaning of "treatment" to the states. Instead, Congress made clear that hospitals must provide any stabilizing treatments that they have the staff and facilities to provide. Making that duty contingent on state law would permit states to circumvent EMTALA's goal of ensuring that hospitals make stabilizing treatments available to all individuals facing emergency situations.

II. EMTALA does not exceed Congress's spending power, as petitioners appear to agree. Petitioners' argument that statutes enacted pursuant to Congress's constitutional exercise of its spending power cannot preempt state law is baseless.

A. The Supremacy Clause declares "the Laws of the United States" to be "the Supreme Law of the Land." Such "Laws" encompass statutes enacted under Congress's spending power as well as those enacted under another enumerated power. This Court has accordingly held that statutes enacted pursuant to the spending power preempt state laws.

This Court has also recognized that, under the spending power, Congress may require recipients of federal funds to comply with substantive requirements and may provide for the enforcement of

those requirements through means other than termination of funding. Under the Supremacy Clause, such requirements are also "Laws" that will have the effect of preempting conflicting state requirements.

B. Petitioners' contrary arguments lack merit. Idaho contends that, notwithstanding its express preemption provision, EMTALA does not preempt conflicting state law and that the appropriate remedy for EMTALA violations caused by a conflicting state-law duty is for the Department of Health and Human Services (HHS) to penalize hospitals. This Court has held, however, that conflicting federal and state duties result in preemption regardless of whether a person can avoid liability by ceasing the regulated activity or paying a penalty. And states should not be able to undermine federal programs by preventing in-state participants from accepting federal funding conditions.

In addition, Congress is not required to obtain a state's consent before preempting state law pursuant to the spending power. Such a limitation on congressional authority would give states *carte blanche* to override EMTALA's requirements, as well as to pick and choose which requirements can be imposed under Medicare and other federal programs. And because a state's refusal to consent to preemption of its laws would not make federal requirements unenforceable against hospitals, the result of petitioners' theory would be to subject hospitals to conflicting state and federal obligations, threatening them with liability whichever obligation they chose to follow and leaving them with no means to resolve the conflict.

The Idaho legislature's concern with the scope of Congress's authority to preempt state law pursuant to

the spending power is misplaced. This Court has recognized that the spending power is not unlimited, and spending conditions that transgress constitutional limits are invalid and unenforceable. Here, however, no party has shown that EMTALA exceeds Congress's spending power. Accordingly, under the Supremacy Clause, EMTALA is "the supreme Law of the Land," and Idaho's conflicting state law must give way.

ARGUMENT

I. EMTALA preempts state laws that restrict hospitals from providing treatment that is required to stabilize an emergency medical condition.

The question presented in this case is a familiar one: Does a federal statute preempt state law? As this Court has recently explained, federal statutes preempt state law when "Congress enacts a law that imposes restrictions or confers rights on private actors [and] a state law confers rights or imposes restrictions that conflict with the federal law." *Murphy v. NCAA*, 584 U.S. 453, 477 (2018). In those circumstances, "the federal law takes precedence and the state law is preempted." *Id.*

EMTALA is undeniably a "federal law." Accordingly, the first step for considering preemption is to determine whether Congress has "impose[d] restrictions or confer[red] rights on private actors," *id.*, and, if so, what those restrictions and rights are. Here, both text and context confirm that EMTALA imposes on hospitals a duty to provide, and on emergency room patients at participating facilities a right to obtain, "such treatment as may be required to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A).

If emergency treatment were required to stabilize a patient who arrived at an emergency department at 4:00 a.m., EMTALA would override a state law barring Medicare-funded hospitals from providing needed emergency treatment between midnight and 7:00 a.m. If a tracheotomy were needed to stabilize a patient in the emergency department, EMTALA would override a state law barring Medicare-funded hospitals from delivering that treatment. And if an abortion is needed to stabilize a patient in the emergency department, EMTALA overrides a state law barring Medicare-funded hospitals from delivering that treatment.

A. Under EMTALA, "any individual" who "comes to the emergency department" of a Medicare-funded hospital is entitled to "an appropriate medical screening examination … to determine whether or not an emergency medical condition … exists." 42 U.S.C. § 1395dd(a). Two subsequent actions flow from the results of that examination. If the "hospital determines that the individual has an emergency medical condition," it "must provide either—(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility." *Id.* § 1395dd(b). The transfer option, however, cannot be exercised until the individual has been "stabilized" unless the individual consents to the transfer or a physician determines that the benefits of transfer outweigh the risks. *Id.* § 1395dd(c).

The plain language of EMTALA's substantive provisions speaks in terms of what a Medicare-funded hospital "must provide" to individuals who come to

emergency rooms seeking medical assistance. That language, phrased in "mandatory" terms, "imposes a binding obligation" on Medicare-funded hospitals to screen individuals for emergency medical conditions and, where such conditions are found, to provide required treatments and appropriate transfers. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 512 (1990) (holding that Medicaid's command with regard to payments that states "must provide" to hospitals is enforceable under 42 U.S.C. § 1983).

Other provisions of EMTALA confirm the point. EMTALA authorizes the federal government to obtain civil money penalties against hospitals and physicians that "violate[] a requirement of [EMTALA]." 42 U.S.C. § 1395dd(d)(1)(A), (B). It also authorizes private civil damages actions against hospitals for a "violation of a requirement of [EMTALA]." *Id.* § 1395dd(d)(2)(A), (B). These enforcement provisions are premised on the existence of affirmative duties imposed on hospitals and physicians.

Moreover, because Congress recognized that a hospital's federal obligations may be inconsistent with its obligations under state law, EMTALA contains an express preemption provision. That provision specifies that EMTALA preempts any State or local law requirement "to the extent that the requirement directly conflicts with a requirement of this section." *Id.* § 1395dd(f). For instance, if a state required a hospital capable of screening and stabilizing an individual to transfer the individual to another medical facility *before* she was stable, the hospital could not comply with the state law without violating its EMTALA duties. *See id.* § 1395dd(a), (b). In that situation, EMTALA would preempt the state law.

B.1. EMTALA's imposition of federal duties on Medicare-funded hospitals is not in serious dispute. Petitioners, however, contest the scope of Medicare-funded hospitals' duty to provide "such treatment as may be required to stabilize [an emergency] medical condition." 42 U.S.C. § 1395dd(b)(1)(A). An "emergency medical condition" exists (other than for women "having contractions") when "the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part." *Id.* § 1395dd(e)(1). In short, an emergency medical condition occurs when a patient is facing a serious health risk.

EMTALA also defines what it means "to stabilize" an emergency medical condition. The hospital must "provide such medical treatment … as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." *Id.* § 1395dd(e)(3)(A). Thus, if a "medical treatment" is necessary to prevent the patient's condition from worsening during a transfer (including a discharge) from the hospital, EMTALA requires the hospital to provide it to the patient.

2. "Statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Engine Mfrs. Ass'n v. S. Coast Air Quality Mgmt. Dist.*, 541 U.S. 246, 252 (2004). Here, Congress imposed on Medicare-funded

hospitals a duty to provide "treatment." Although "treatment" is not defined in the statute, its ordinary meaning is "a therapeutic agent, therapy, or procedure used to treat a medical condition." *Treatment*, Merriam-Webster: Dictionary, https://www.merriam-webster.com/dictionary/treatment#medicalDictionary (last visited Mar. 25, 2024); *Treatment*, *Black's Law Dictionary* (6th ed. 1990) ("[a] broad term covering all the steps taken to effect a cure of an injury or disease"); *The American Heritage Dictionary of the English Language* 1367 (1981) (defining "treatment" as "application of remedies with the object of effecting a cure; therapy").

As a factual matter, the record supports the conclusion that an abortion may be the "treatment" required to "stabilize" certain medical conditions. U.S. Br. 14–16, 19. Indeed, that principle appears to be undisputed. Idaho law itself recognizes that an abortion may be needed "to prevent the death of the pregnant woman," Idaho Code § 18-622(2)(a)(i), and petitioners do not contest that an abortion may be effective in preventing deterioration of certain medical conditions that pose a serious health risk if left untreated, Idaho Leg. Br. 12–14 (asserting that government's examples of medical conditions that require termination of a pregnancy "were either life-saving procedures or otherwise not abortions" (cleaned up)). And this Court has long recognized that there are "medically necessary" reasons for abortions. *See Harris v. McRae*, 448 U.S. 297, 311 (1980).

Other federal laws reinforce the conclusion that an abortion is a "treatment" for certain medical conditions. The Hyde Amendment generally prohibits the expenditure of appropriated funds for abortions. *See* Consolidated Appropriations Act, 2023, Pub. L.

No. 117-328, div. H, tit. V, § 506(a), 136 Stat. 4459, 4908 (2022). That restriction, however, does not apply "in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed." *Id.* § 507(a)(2). Thus, federal funds can be used to pay for abortions to treat life-threatening medical conditions precisely because abortion may be the appropriate medical treatment in some circumstances.

Medicaid also recognizes abortion as a treatment. It requires participating states to have a system for imposing sanctions on a "managed care organization" that "fails substantially to provide medically necessary items and services that are required … to be provided to an enrollee." 42 U.S.C. § 1396u-2(e)(1)(A)(i). Reflecting that the plain language of that provision would apply to failure to provide abortion services, the statute includes an express exception under which a managed care organization can be sanctioned for not providing medically necessary abortions only if it "has a contract to provide abortion services." *Id.* § 1396u-2(e)(1)(B).

The Affordable Care and Patient Protection Act (ACA) expressly recognizes that abortions are a possible treatment under EMTALA. The ACA requires health insurance exchanges to "make available qualified health plans to qualified individuals," *id.* § 18031(d)(2), and defines the "essential health benefits" that must be offered through such plans, *id.* §§ 18021(a)(1)(B), 18022. But the ACA also gives states and plans leeway to include or exclude coverage for abortions, *id.* § 18023(a)(1),

and specifically provides that the ACA does not "relieve any health care provider from providing emergency services" under EMTALA, *id.* § 18023(d). These provisions are premised on the recognition that abortion is a treatment for certain medical conditions and thus is the type of service that could be covered by an individual's health insurance plan and the type of treatment that may be needed to treat an emergency medical condition.

Because abortion is a "treatment," EMTALA requires Medicare-funded hospitals to provide the treatment when "required to stabilize the medical condition," that is, when the failure to provide the treatment "could reasonably be expected to result" in a serious health risk to the individual. *Id.* § 1395dd(b)(1)(A), (e)(1). Idaho law, however, "imposes restrictions that conflict with the federal law" in certain circumstances. *Murphy*, 584 U.S. at 477. Under Idaho law, a hospital may lawfully terminate a pregnancy as a treatment for a medical condition only in case of the "removal of a dead unborn child," the "removal of an ectopic or molar pregnancy," or "to prevent the death of the pregnant woman." Idaho Code §§ 18-604(1)(b), (c), 18-622(2)(a)(i). Those situations are narrower than the circumstances in which an abortion may be required under EMTALA. Thus, if the individual faces one of several serious but not immediately life-threatening health risks—*e.g.*, rupture of the amniotic sac, placental abruption, and uterine hemorrhaging, *see* U.S. Br. 7, 14, 23–24—the physician could not comply with EMTALA's requirements without risking criminal penalties under Idaho law. Idaho law and EMTALA thus "directly conflict[]." 42 U.S.C. § 1395dd(f).

3. Petitioners argue that this Court should not interpret the term "treatment" in EMTALA according to its ordinary meaning. Instead, they argue that each state may decide what constitutes a "treatment" for purposes of enforcing EMTALA's requirement that hospitals "provide … such treatment as may be required to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A); *see* Idaho Br. 26; Idaho Leg. Br. 25. That view cannot be reconciled with EMTALA's text or purpose.

First, EMTALA does not delegate to states the authority to interpret the meaning of "treatment." Congress knew how to reference state law in EMTALA, *see* 42 U.S.C. § 1395dd(d)(2), as well as in Medicare generally, *see, e.g.*, *id.* §§ 1395i-3(c)(3)(E), 1395i-5(b)(5)(A)(ii), 1395x(aa)(5)(A), but did not do so in imposing duties on hospitals. Moreover, Congress imposed only one condition on hospitals' duty to provide a required "treatment"—that such treatment be "within the staff and facilities available at the hospital." *Id.* § 1395dd(b)(1)(A). In other words, although EMTALA does *not* require a hospital to be capable of providing every possible treatment to an individual, if the hospital is capable of providing a particular treatment, it must do so. State law that contradicts EMTALA's instruction is preempted.

Second, making the duty to provide treatment contingent on state law would permit states to circumvent EMTALA's goal of providing all emergency room patients with access to needed stabilizing treatment. A state seeking to reduce emergency room costs, for instance, could provide that expensive treatments must be used only for life-threatening conditions, which would circumvent the hospital's duty under EMTALA to stabilize conditions that pose

a serious, but not life-threatening, health risk. Or a state could require treatment variations based on a patient's age or medical condition. A state hostile to drug users could preclude hospitals from treating opioid overdose victims with naloxone. A state could conclude that no treatment is indicated for a fetus, effectively nullifying EMTALA's requirement that the health of an "unborn child" should inform treatment options available to physicians and patients. *See id.* § 1395dd(e)(1)(A)(i). Congress did not intend to permit states to override EMTALA's duties in this manner; to the contrary, it intended to preempt conflicting state law. *Id.* § 1395dd(f).

Third, petitioners' invocation of the major-questions doctrine does not change the preemption analysis. *See* Idaho Br. 21–22; Idaho Leg. Br. 38–47. As the Court has explained, the major-questions doctrine applies "in certain extraordinary cases," in which the Court is "'reluctant to read into ambiguous statutory text' the delegation claimed to be lurking there." *West Virginia v. EPA*, 597 U.S. 697, 723 (2022) (quoting *Util. Air Reg. Grp. v. EPA*, 573 U.S. 302, 324 (2014)). Here, the issue is not whether EMTALA has delegated to HHS the power to require hospitals to require medically needed treatments. The issues are whether EMTALA's plain text imposes that requirement directly and, if so, whether it preempts contrary state-law commands. Those issues do not implicate the major questions doctrine.

II. The Supremacy Clause does not exclude laws enacted pursuant to Congress's spending power.

Petitioners have not shown that the substantive obligations that EMTALA imposes on Medicare-

funded hospitals fall outside of Congress's power to decide how to spend tax dollars "to provide for the … general Welfare of the United States." U.S. Const. art. I, § 8, cl. 1. They argue, however, that state laws that require Medicare-funded hospitals to violate obligations imposed by EMTALA are not preempted under normal conflict-preemption principles. *See* Idaho Br. 20–21; Idaho Leg. Br. 48–51; *see also* Indiana Br. 14; Prolife Center Br. 11–12. In their view, federal statutes, such as Medicare, that Congress enacts pursuant to its spending power lack the preemptive force of federal statutes enacted pursuant to Congress's other enumerated powers. That view, which would sweep well beyond the immediate issue of emergency room abortions, cannot be reconciled with the text of the Supremacy Clause or this Court's precedents.

A. As this Court has explained, federal statutes do not of their own force preempt conflicting state laws. Rather, "[p]reemption is based on the Supremacy Clause," *Murphy*, 584 U.S. at 477, which provides that the "Constitution, and the Laws of the United States which shall be made in Pursuance thereof … shall be the supreme Law of the Land … any Thing in the Constitution or Laws of any State to the Contrary notwithstanding," U.S. Const. art. VI, cl. 2. The Supremacy Clause "creates a rule of decision" that "instructs courts what to do when state and federal law clash." *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 324–25 (2015). Although the Supremacy Clause "is not a source of any federal rights[,] it secures federal rights by according them priority whenever they come in conflict with state law." *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989) (cleaned up).

Importantly here, "all federal rights, whether created by treaty, by statute, or by regulation, are 'secured' by the Supremacy Clause." *Chapman v. Hous. Welfare Rts. Org.*, 441 U.S. 600, 613 (1979). That much is evident from the text of the Supremacy Clause itself, which refers to the primacy of "the Laws of the United States which shall be made in Pursuance" of the Constitution. U.S. Const. art. VI, cl. 2. The Constitution elsewhere describes the process that Congress must undertake for a bill to "become a Law." *Id.* art. I, § 7, cl. 2. And the Constitution's enumeration of the "Power[s]" that Congress may exercise through its law-making authority lists the spending power first of all. *Id.* art. I, § 8. Nothing in the constitutional text suggests that a statute enacted pursuant to Congress's spending power is not one of "the Laws of the United States" that "shall be the supreme Law of the Land." *Id.* art. VI, cl. 2.

Not surprisingly, then, in several cases, this Court has held that federal statutes enacted pursuant to the spending power preempt conflicting state laws. For instance, Social Security retirement benefits are an exercise of Congress's spending power. *See Flemming v. Nestor*, 363 U.S. 603, 610–11 (1960) (explaining that Social Security was "enacted pursuant to Congress' power to 'spend money in aid of the "general welfare,"'" (quoting *Helvering v. Davis*, 301 U.S. 619, 640 (1937)). In *Bennett v. Arkansas*, 485 U.S. 395 (1988) (per curiam), this Court held that the Social Security Act's bar on attaching Social Security benefits through legal process preempted an Arkansas law to seize the Social Security benefits of prisoners to "defray the cost of maintaining its prison system." *Id.* at 396–97. The Court declined to read an "implied exception" into the Social Security Act to avoid the

"clear inconsistency" between the Social Security Act and Arkansas law. *Id.* at 397. Instead, the Court explained that there was "a 'conflict' under the Supremacy Clause—a conflict that the State cannot win." *Id.* (citing *Rose v. Ark. State Police*, 479 U.S. 1, 4 (1986) (per curiam) (holding that state law that offset state benefits based on amount of federal supplemental benefits was "repugnant to the Supremacy Clause" because it "authorize[d] the precise conduct that Congress sought to prohibit")).

Likewise, in *Lawrence County v. Lead-Deadwood School District No. 40-1*, 469 U.S. 256 (1985), the Court held that a state may not "regulate the distribution of funds that units of local government in that State receive from the Federal Government in lieu of taxes," *id.* at 257–58, because Congress had provided that local units "may use the payment for any governmental purpose," *id.* at 258 (quoting 31 U.S.C. § 6902(a)). The Court rejected the argument that denying states the authority to direct how localities use the funds would raise federalism concerns, concluding that "pursuant to its powers under the Spending Clause, Congress may impose conditions on the receipt of federal funds, absent some independent constitutional bar." *Id.* at 269–70.

That EMTALA imposes substantive obligations only on hospitals that agree to accept Medicare funding does not affect the preemption analysis. "Congress has broad power under the Spending Clause of the Constitution to set the terms on which it disburses federal funds." *Cummings v. Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212, 216 (2022). Such terms often include the imposition of substantive obligations on entities that accept federal funds, such as the duty to refrain from discriminating against, or failing to

accommodate, a protected class of beneficiaries. *See id.*; *see also Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 198 n.2 (2023); *Sossamon v. Texas*, 563 U.S. 277, 281 (2011); *Davis v. Monroe Cnty. Bd. of Educ.*, 526 U.S. 629, 632–33 (1999). And "healthcare facilities that wish to participate in Medicare and Medicaid have always been obligated to satisfy a host of conditions that address the safe and effective provision of healthcare." *Biden v. Missouri*, 595 U.S. 87, 94 (2022). As the Court held last term in *Health & Hospital Corp. of Marion City v. Talevski*, 599 U.S. 166 (2023), substantive obligations imposed pursuant to the spending power are "laws" that may be enforced through the imposition of civil liability, as well as through the termination of funding. *Id.* at 183–84.

To be sure, obligations enacted pursuant to the spending power, like obligations imposed through Congress's other enumerated powers, may be invalid if they violate the recipient's constitutional rights, notwithstanding the recipient's ability to avoid the condition by declining the funds. *See*, *e.g.*, *Agency for Int'l Dev. v. All. for Open Soc'y Int'l, Inc.*, 570 U.S. 205, 214 (2013) (holding that spending condition violated recipient's First Amendment rights). But "[i]n every such case" where the spending condition is "made in pursuance of the constitution," "the act of Congress … is supreme; and the law of the State … must yield to it." *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211 (1824); *see also Haaland v. Brackeen*, 599 U.S. 255, 287 (2023) ("[W]hen Congress enacts a valid statute pursuant to its Article I powers, state law is naturally preempted to the extent of any conflict with a federal statute." (internal quotation marks omitted)).

B. Petitioners' arguments that federal spending statutes do not have preemptive effect lack merit. To begin, Idaho argues that because hospitals have "the option of ceasing to act" under EMTALA by declining to participate in Medicare, the appropriate remedy for any EMTALA violation "is to seek penalties against hospitals who accept funds but fail to comply with its requirements," not to enforce EMTALA by requiring hospitals to provide emergency treatment that state law prohibits. Idaho Br. 21 (citing *Mut. Pharm. Co. v. Bartlett*, 570 U.S. 472, 488 (2013)). As Idaho recognizes, however, *Mutual Pharmaceutical* held that "an actor seeking to satisfy both his federal- and state-law obligations is *not* required to cease acting altogether in order to avoid liability" when federal and state law conflict; instead, the conflicting state law is preempted. 570 U.S. at 488 (emphasis added). Adherence to that principle is especially important when the activity that would need to be halted is participation in a federal program. Otherwise, any state would be able to frustrate the implementation of any aspect of any federal spending program with which the state disagrees by imposing conflicting requirements or prohibitions on persons subject to the state's jurisdiction.

Invoking the principle that Spending Clause legislation "is much in the nature of a contract," *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981), petitioners contend that a federal program enacted pursuant to the spending power cannot preempt conflicting state law without the state's consent, *see* Idaho Br. 20; Idaho Leg. Br. 49–51. But this Court has used the contract-law "analogy" to ensure that the *recipient* of the funds understands the obligations and remedies that are attached to federal funds and "voluntarily and knowingly accepts the

terms." *Cummings*, 596 U.S. at 218–20. This Court has never suggested that the analogy can be stretched to the point where the federal statutes that establish a spending program are not "Laws" within the meaning of the Supremacy Clause. As this Court explained in holding that obligations imposed by a spending program create federal rights enforceable under 42 U.S.C. § 1983, "'laws' indeed means 'laws.'" *Talevski*, 599 U.S. at 177 (citing *Maine v. Thiboutot*, 448 U.S. 1, 4–6 (1980)). Thus, once the recipient of federal funding (here, the hospital) has consented to accept the funding conditions, federal law requires it to comply notwithstanding any contrary state law. Consent by the state to the choice-of-law rule imposed by the Supremacy Clause is not required.

Indeed, if federal spending programs could not preempt state law, states could override *any* of EMTALA's requirements related to screening, treating, and transferring emergency room patients, as well as other Medicare provisions. *See* 42 C.F.R. pt. 482 (establishing conditions for hospital participation in Medicare). For instance, Medicare bars states from imposing "premium taxes" on payments and premiums paid to Medicare+Choice organizations, 42 U.S.C. § 1395w-24(g), and on prescription drug plans and sponsors participating in Part D drug plans, *id.* § 1395w-112(g). Medicare also establishes uniform payment structures for certain entities that "supersede" state law. *See Medicaid & Medicare Advantage Prods. Ass'n of P.R., Inc. v. Emanuelli Hernández*, 58 F.4th 5, 9 (1st Cir. 2023) (quoting 42 U.S.C. § 1395w-26(b)(3)). Under petitioners' theory, these efforts to establish a uniform federal standard for Medicare would be in question. Given the devastating effects of petitioners' proposed rule on

federal spending initiatives, it is not surprising that they cannot identify any precedent to support the principle that federally imposed obligations on private parties depend on state consent for their efficacy.

Moreover, a consent requirement would be wholly unworkable because it would not resolve the conflict between federal and state law. That is because, even assuming state consent were constitutionally required for state law to be preempted by EMTALA, a state's withholding of such consent would not bar enforcement of EMTALA requirements against hospitals. Accordingly, the effect of a state-consent requirement would be to leave both state and federal laws in effect "like equal opposing powers." *Gibbons*, 22 U.S. (9 Wheat.) at 210. That is precisely the situation the Supremacy Clause was designed to avoid. *Id.*

The Idaho legislature asks this Court to disregard the constitutional design out of concern that Congress may use the spending power as "an instrument of unlimited federal power." Idaho Leg. Br. 49. As this Court has held, the "spending power is of course not unlimited," but in fact "subject to several general restrictions." *South Dakota v. Dole*, 483 U.S. 203, 207 (1987). The Court there explained that, when the state is the recipient of federal funds, federal spending programs must "be in pursuit of the general welfare," conditions on funding must be "unambiguous[]," the conditions must be related "to the federal interest in particular national projects or programs," and the conditions cannot violate "other constitutional provisions." *Id.* at 207–08 (internal quotation marks omitted).

EMTALA does not transgress these limits, and petitioners do not demonstrate that EMTALA imposes

conditions that exceed Congress's spending power. Without a showing that EMTALA itself is unconstitutional, there is no basis in the Supremacy Clause, this Court's precedent, or logic for concluding that hospitals are simultaneously required to comply with their obligations under EMTALA and conflicting state laws. Accordingly, either EMTALA's requirements or Idaho's abortion restrictions must give way. The Supremacy Clause supplies the answer. *See Bennett*, 485 U.S. at 397 (stating that a "'conflict' under the Supremacy Clause" is "a conflict that the State cannot win").

CONCLUSION

For the foregoing reasons and the reasons stated in respondent's brief, the judgment of the district court should be affirmed.

Respectfully submitted,

NANDAN M. JOSHI
Counsel of Record
ALLISON M. ZIEVE
SCOTT L. NELSON
PUBLIC CITIZEN
LITIGATION GROUP
1600 20th Street NW
Washington, DC 20009
(202) 588-1000
njoshi@citizen.org

Attorneys for Amicus Curiae

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